Atrium Health Wake Forest Baptist

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Wake Forest Baptist Infusion- Westchester **Fax** 336-802-2389

Tocilizumab or Biosimilar Infusion Order (Revised 06/02/2026)

All orders with a √ will be placed.

Patient Demographics:

Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:

Allergies: (please list all allergies or attach list)

☐ NKDA

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)

☐ M05._____ Rheumatoid Arthritis with rheumatoid factor	☐ M06._____ Rheumatoid Arthritis without rheumatoid factor
☐ M31.6 - Other Giant Cell Arteritis	☐ M31.5 - Giant Cell Arteritis with Polymyalgia Rheumatica
☐ Other:	

Required Documentation: (*required prior to scheduling*)

Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:

☑ Hold treatment and notify provider IF:
- Temperature is GREATER THAN 100oF;
- Patient complains of symptoms of acute viral or bacterial infection;
- Patient is taking an antibiotic for current infection.

☑ Hold treatment and notify provider IF: Patient presents with new onset abdominal symptoms (symptoms of abdominal perforation include: constellation of distended, hard, tympanic abdomen, almost absent bowel sounds, fever/chills, abdominal tenderness, toxic appearance, and not passing any gas); Patient presents with signs and symptoms potentially indicative of demyelinating disorders.

☑ Required Lab Results: Hep B Profile and PPD/Quantiferon Gold PRIOR to FIRST treatment, and CBC with diff, ALT, AST, Serum Creatinine PRIOR to treatment (**Fax labs with order**)

☑ Hold Treatment and Notify Provider IF: Hep B Panel: POSITIVE or not on file; PPD/Quantiferon Gold: POSITIVE or not on file; ANC less than 2000 PRIOR to INITIATION of treatment; ANC less than 1000, or not on file; ALT/AST ABNORMAL, or not on file; Platelet Count less than 100,000, or not on file; Serum Creatinine ABNORMAL, or not on file.

☑ After the 4th set of labs, if the ANC has remained GREATER THAN OR EQUAL TO 1000, AST and ALT have remained NORMAL, then patient may have labs done every 3 months.

Provider Communication:

☑ Use tocilizumab with caution in patients who may be at risk for gastrointestinal perforation and in patients with pre-existing or recent onset of demyelinating disorders.

Nursing Communication:

☑ Start PIV/Access CVC and flush device per approved Atrium Health protocol.

☑ Obtain vital signs PRE-treatment and POST-treatment. Obtain vital signs PRN during treatment.

☑ Monitor patient for signs of reaction for 30mins after completion of 1st infusion and subsequent infusions PRN if previous signs of reaction observed.

Pre-Medications: (Administer all pre-medications 30mins prior to treatment)

☐ Acetaminophen (Tylenol) 650mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg PO ONCE

☐ Diphenhydramine (Benadryl) 25mg IV ONCE

☐ Loratadine (Claritin) 10mg PO ONCE

☐ Methylprednisolone sodium succinate (Solu-Medrol) 125mg IV ONCE

Infusion Therapy:

☐ FIRST Dose

☐ Tocilizumab or biosimilar IVPB 4mg/kg over 60mins ONCE	☐ Tocilizumab or biosimilar IVPB 8mg/kg over 60mins ONCE
☐ Tocilizumab or biosimilar IVPB 6mg/kg over 60mins ONCE	☐ Tocilizumab or biosimilar IVPB 12mg/kg over 60mins ONCE

☐ SUBSEQUENT dose: (**Start 4 weeks after the first dose**)

☐ Tocilizumab or biosimilar IVPB 4mg/kg over 60mins every 4 weeks	☐ Tocilizumab or biosimilar IVPB 8mg/kg over 60mins every 4 weeks
☐ Tocilizumab or biosimilar IVPB 6mg/kg over 60mins every 4 weeks	☐ Tocilizumab or biosimilar IVPB 12mg/kg over 60mins every 4 weeks

☑ **Atrium Health will authorize the payer preferred tocilizumab product Please list any contraindicated tocilizumab product:Please list the reason for the contraindication:**

Supportive Care Medications:

☑ Acetaminophen (Tylenol) 650mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first if not given as a pre-medication.

☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.

☑ Ondansetron (Zofran) 4mg IV ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:

☑ Initiate Atrium Health Wake Forest Baptist approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Wake Forest Baptist Infusion - Westchester website at wakehealth.edu/locations/clinics/i/infusion-westchester

Prescriber Information:

Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted

Signature:	Date: